VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
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Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

March 12, 2012

Ms. Ursula Margazano, Administrator
Burlington Health & Rehab
300 Pearl Street
Burlington, VT 05401

Provider #: 475014

Dear Ms. Margazano:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **February 15, 2012 .** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN, MS
Licensing Chief

PC:ne

Enclosure

RECEIVED
Division of
MAR -5 12
Licensing and Protection

PRINTED: 02/21/2012
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475014	A. BUILDING ______ B. WING ______	C 02/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURLINGTON HEALTH & REHAB	300 PEARL STREET BURLINGTON, VT 05401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced onsite follow-up survey on 2/15/12. A regulatory violation was cited as a result.	F 000	**The following constitutes the facility's response to the findings of the Department of Licensing and Protection and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statement of deficiencies.**	
F 468 SS=B	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to equip corridors with firmly secured handrails on 1 floor of the facility. Findings include: Per observation during a tour of the fourth floor unit on 2/15/12 at 10:22 AM, 3 handrails were loose, creating a potential accident hazard. Two of the loose rails were on the east wall of the resident dining area. The third loose rail was on the west wall of the dining area adjacent to the ice machine. Additionally, one of the east rails could be pulled from the corner, creating a sharp-edged gap that could potentially pinch or cut. On 2/15/12 at 12:40 PM, the Unit Manager confirmed that the rails were loose and agreed that they created a potential accident hazard.	F 468	The facility maintains that it provides that it equips it's corridors with firmly secured handrails on each side. **How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice? :** Unit 4 residents had no negative outcomes from this alleged deficient practice. The two loose rails on the east wall and the one loose rail on the west wall of the dining area were adjusted to eliminate the gap/edge at the corner and re-anchored / tightened to wall. **Maint Director, Administrator, &/or designee** **How will the facility identify other residents having the potential to be affected by the same deficient practice? :** All residents are potentially affected by this alleged deficient practice.	2/15/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 2/29/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

pmc

Cont F468	**What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? :** Maintenance completed at check of all handrails and specified as a part of the Preventative Maint Program. Maintenance Staff was re-educated re: documentation of outcomes related to PMP and f/u re: completion of tasks related to PMP outcomes. **Maintenance Director, Administrator &/or designee**	**2/16/2012 On-going**
	How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? : 5 random audits per week per unit Xs 4 weeks of hand rail stability with results reported at Action Team and QA Meetings with changes made as appropriate. **Maintenance Director &/or designee** F468 POC approved 3/9/12 RTremblay RN/DNCertain RN	**2/15/2012 On-going**

Burlington Health